

EMS COMPLIANCE AND QUALITY ASSURANCE GROUP <u>COMMUNITY SUPERVISION FORM</u>

This form is used to determine if the Emergency Medical Service (EMS) Applicant/Certificant/Licensee is compliant with his or her community supervision/probation requirements. Please return the completed form to: **MAIL:** Department of State Health Services, EMS Compliance and Quality Assurance, Mail Code 1979, P.O. Box 149347, Austin, Texas 78714-9347 or **FAX** to 512-834-6713.

SECTION 1: To be completed by EMS Ap LAST	FIRST	MIDDLE	
JAME:		DATE	
		DATE OF BIRTH:	
OCIAL SECURITY NUMBER:		(mm/dd/yy)	
SECTION 2: To be completed by EMS Ap	oplicant/Certificant/Lice	see	
a Quality Assurance, to receive information related Safety Code which requires evidence to assist esponsibilities of emergency medical service	ted to my community superindetermining the fitness	rvision pursuant to Chapter 773 of the He	and alth and
Signature of Applicant)		(Date)	
SECTION 3: To be completed by Communication pertinent to the complete			
	ion of this section or a	lditional sheets if necessary.	
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the EMS applicant/certificant/licensee in answered no, please provide an explanati	compliance with super	lditional sheets if necessary.	